Reset Form

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN
FOR TYPE B FAMILY CHILD CARE AND IN-HOME AIDES

Child's Name	Date of Birth
Special Health Conditions	
Symptoms to watch for and emergency action to be taken if the following symptoms occur	
Activities/Foods/Environmental Conditions to Avoid	
Medical Procedures to be followed and Expected Benefit of Treatment	

Are any medications required? ☐ **No** ☐ **Yes** (If yes, complete JFS 01644 Request for Administration of Medication)
If yes, what medications?

Training Instructions (Trainer must be a caretaker/parent or certified professional)	
Signature of Trainer	Date

Signature of trained providers who have been made aware of the condition.
(There must always be a trained provider present when the child is present.)

Signature _____ Date _____ ☐ Provider Informed ☐ Provider Trained

Signature _____ Date _____ ☐ Caregiver Informed ☐ Caregiver Trained

(Only trained providers or emergency or substitute caregivers shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving
Who provides the above services?

Name _____ Phone number _____ May we contact? ☐ No ☐ Yes

Name _____ Phone number _____ May we contact? ☐ No ☐ Yes

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Caretaker/Parent Signature	**Date**
Provider Signature	**Date**

This form may be used for children with health conditions as defined in Rules 5101: 2-14-27.